Toolkit of Promising Practices for Financing Integrated Care in the California Safety Net

Dale Jarvis, CPA
dale@djconsult.net

Quick Reminders About Your Audio

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- Make sure this button is clicked if you’re calling in by telephone
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Mechanics of Q&A

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Context for the Toolkit – The New Healthcare Ecosystem
Today’s Agenda

1. Introduction to the Toolkit
2. Brief History Lesson
3. Eight Steps to Integrated Care
4. The Top Ten Barriers
5. Tomorrow’s Payment Models
6. Epilogue: The Customization of the Medical Home
Be thinking bout...

• What is one question you’d like answered today?
• What is one problem you’d like solved today?

Introduction to the Toolkit
Why this Toolkit?

To figure out how to ensure that California projects doing this cutting edge work don’t go bankrupt in the process?

Two Audiences...

• Provider Organizations (MH, SU, Health)
  – How do you navigate the existing funding maze?

• Payors/Managers (Counties, MISP/CMSPs, etc.)
  – What can you do to create a more supportive payment and regulatory system (today and tomorrow)?
Across the Continuum of Those Working on Integration...

• Are you contemplating an integration project?
• Are you deep into planning the project?
• Are you well underway?

Warning
Read Before Proceeding!

• “By all rights, every project should have failed. We have identified ten major funding obstacles and chronicled countless stories about cultural differences, political hurdles, turf battles, personality clashes, and more.”
Quick Guide

<table>
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<th>Section</th>
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<td>II: Quick Guide</td>
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<td>III: Background</td>
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<td>IV: Follow the Money</td>
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<td>V: Barriers</td>
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<td>VI: Opening the Toolkit</td>
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<td>VII: How You Will Get Paid Tomorrow</td>
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<td>VIII: Final Thoughts</td>
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Brief History Lesson
A Tale of 3 Siblings

Why this toolkit? It's really a story of 3 “safety net” siblings separated when children-the Health (FQHC), MH and SU (ADP) Systems

Community Health Centers

<table>
<thead>
<tr>
<th>Decade</th>
<th>Legislation/Program</th>
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<tbody>
<tr>
<td>1960s</td>
<td>Migrant Health Act of 1962 for farm workers/families</td>
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<tr>
<td></td>
<td>Economic Opportunity Act of 1964 funds CHCs</td>
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<tr>
<td>1970s</td>
<td>Section 330 of the Public Health Services Act</td>
</tr>
<tr>
<td></td>
<td>- Community Health Center Program – Section 330(e)</td>
</tr>
<tr>
<td></td>
<td>- Migrant Health Center Program – Section 330(g)</td>
</tr>
<tr>
<td></td>
<td>National Health Service Corps begins</td>
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<tr>
<td>1980s</td>
<td>Health Care for the Homeless Program – Section 330(h)</td>
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<td></td>
<td>Health Center Cost-Based Payments for Medicare &amp; Medicaid</td>
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<tr>
<td>1990s</td>
<td>Free Federal Tort Protection (Malpractice Insurance)</td>
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<td></td>
<td>Public Housing Primary Care Program – Section 330(i)</td>
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<tr>
<td>2000s</td>
<td>Prospective Payment System replaces Cost-Based Model</td>
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<tr>
<td></td>
<td>States Required to Cover Difference between Rates &amp; PPS</td>
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<td></td>
<td>Expansion of Funding and Capacity, adding BH Services</td>
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</tbody>
</table>
CMHCs: De-Federalized Program Managed by the States

Sister of CHCs in the 1960s and 1970s
Part of the *Shift and Shaft* strategy that began in 1981
Leaving success or failure up to each state’s leadership and funding levels and the ability of local CBHOs to succeed (or not) in a highly regulated and underfunded environment.

Meanwhile...

- The dysfunction of the rest of the American Healthcare System has been creating a huge *sucking sound* in the American Economy (next chapter)
- And funding for the safety net has taken a back seat to *centers of power*: insurance companies, pharmaceutical companies, hospitals, specialty physicians, etc...

<table>
<thead>
<tr>
<th>Source: HRSA, NASMHPD, SAMHSA, Kaiser, Commonwealth Fund</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FQHC Funding</strong></td>
<td>$9.1  0.3%</td>
</tr>
<tr>
<td><strong>CMHC Funding</strong></td>
<td>$19.7  0.7%</td>
</tr>
<tr>
<td><strong>Combined Funding</strong></td>
<td>$28.8  1.0%</td>
</tr>
<tr>
<td><strong>US Healthcare Funding</strong></td>
<td>$2,776 100%</td>
</tr>
<tr>
<td><strong>Medicaid or Indigent/Uninsured</strong></td>
<td>69  22%</td>
</tr>
<tr>
<td><strong>Total US Residents</strong></td>
<td>307 100%</td>
</tr>
</tbody>
</table>
What’s Next: The future of Health and Behavioral Healthcare Organizations in America

- The head is being reconnected to the body
- Your presence here today signifies that you are on the leading (and hopefully not bleeding) edge of this change process

Another View of the Ecosystem
Questions? dale@djconsult.net

- What is one question you’d like answered today?
- What is one problem you’d like solved today?

Opening the Toolkit
How to Get Paid Today for Integrated Care

1. Engage Top Leadership and Identify a Project Champion
2. Organize a Planning Workgroup and Prepare a High Level Project Timeline
3. Design the Clinical Model
4. Identify and Address your Funding Barriers
5. Design a Detailed Implementation Plan
6. Prepare a Detailed Integration Budget
7. Revise your Infrastructure and Obtain Necessary Approvals
8. Go Live; Monitor and Adjust As Needed
Step 1: Engage Top Leadership and Identify a Project Champion

- The senior leadership of the PC and BH systems have made a strong commitment to ensuring the success of the project and follows through.
- Each project has a dedicated champion with optimism, tenacity, attention to detail, and belief that the project can make a difference.

Step 2: Organize a Planning Workgroup and Prepare a High Level Project Timeline

- Healthcare is quickly moving from an individual sport to a team sport.
- Thus, the importance of a multidisciplinary workgroup involving local primary care, mental health, and substance use integration partners.
Step 3: Design the Clinical Model

New Patient’s first Visit to PCP includes behavioral health screening

Possible BH Issues?

YES

Behavioral Health Assessment by BH Professional working in primary care

Need BH Svcs?

YES

Clients with Low to Moderate BH need enrolled in Level 1; to be case managed and served in primary care by PCP and BH Care Coordinator with support from Consulting Psychiatrist and other clinic-based Mental Health Providers

Clients with High/Moderate to High need referred to Level 2 specialty care; PCP continues to provide medical services and BH Care Coordinator maintains linkage; this is a time-limited referral with expectation that care will be stepped back to primary care

Referrals to other needed services and supports (e.g. CSO, Vocational Rehabilitation)

Person Centered Healthcare Home Clinical Design based on IMPACT Model
- Systematic outcomes tracking (e.g. PHQ-9 for depression, GAD-7 for anxiety)
- Treatment adjustment as needed including stepped care (e.g. up to specialty BH) (based on clinical outcomes, evidence-based algorithm; in consultation with team psychiatrist)
- Relapse prevention

Step 4: Identify and Address Your Funding Barriers

Case in Point: The Walls of Dubrovnik, Croatia were considered to be amongst the great fortification systems of the Middle Ages, as they were never breached by a hostile army. If you are facing similar financing barriers, find a new castle to storm and move on to other ways to finance your integration project.
This can be done by sketching out the most frequent clinical workflows in your integration project and noting how each step in the flow will be funded – or not.

Step 5: Design a Detailed Implementation Plan

Many successful projects organize their implementation into multiple phases, as opposed to a “big bang” approach that attempts to bring the entire integration plan online at once.
Step 6: Prepare a Detailed Integration Budget

1. Project how many people will be served in the integrated care program
2. Estimate services volumes based on the estimated level of need of the population who will be served (visits per person, per year)
3. Identify staffing levels, by position and location, needed to serve the population
4. Calculate the fully-loaded staffing costs
5. Estimate the startup costs, ongoing technical assistance expenses, and other items outside the normal budget
6. Map service volumes to payer source (e.g., Health Center PPS encounters, SD-MC visits, Drug Medi-Cal visits) and project the per-visit revenue
7. Compare revenues and expenses before additional funding; determine the level of grant support and MHSA funding to fill the gaps
8. If the project isn’t affordable, make any needed clinical design changes to balance the budget

Step 6: Prepare a Detailed Integration Budget

<table>
<thead>
<tr>
<th>Clinician</th>
<th>Service</th>
<th>Site</th>
<th>Funding Source</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMPACT Model Team</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>Prescriber</td>
<td>FQHC</td>
<td>FQHC PPS</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Professional</td>
<td>Care Coordinator</td>
<td>FQHC</td>
<td>Short Doyle Medi-Cal, FQHC PPS</td>
<td>Non-Realignment Medi-Cal</td>
</tr>
<tr>
<td>Consulting Psychiatrist</td>
<td>Consultation</td>
<td>FQHC</td>
<td>MHSA PPS</td>
<td></td>
</tr>
<tr>
<td>Primary Care Team in MH Center</td>
<td>Primary Care</td>
<td>MH Center</td>
<td>FQHC PPS</td>
<td>Expand FQHC Scope of Practice</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Nurse Care Manager</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Supervising MD</td>
<td>Supervision</td>
<td>MH Center</td>
<td>FQHC PPS</td>
<td></td>
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</tbody>
</table>

- Budget for services in the primary care clinic
- Budget for services in the behavioral health center
Step 7: Revise your Infrastructure and Obtain Necessary Approvals 
(The devil is in the details)

- Does the Health Center require a change in Scope of Project due to changes in services, providers and places where those providers provide services?
- Who will own the charts and how will documentation be shared?
- Will a shared patient registry be implemented that tracks key demographic, utilization, and clinical information?
- Are we currently capturing the appropriate data in the primary care clinic and behavioral health center to properly bill and be paid for services?

Don’t let your project get derailed by the need for a sink!
Step 8: Go Live; Monitor and Adjust, As Needed

• The future is in Rapid Cycle Improvement, not plastics...

Questions?

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Toolkit of Promising Practices for Financing Integrated Care in the California Safety Net, Part 2

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The “Top Ten” Barriers to Getting Paid for Integrated Care

Top 10 Barriers

1. Health Center Billing of MH/SU Services
2. Limitations on Who Can Bill for Services
3. Psychiatric Consultation to Primary Care Provider/Care Manager
4. Lack of Codes for Non Face-to-Face Psychiatric Consultation, Care Management, and SBIRT
5. Barriers to Team-Based Care
6. Mental Health Diagnosis as Primary in Primary Care
7. Inability to Bill for Telephone, Telemedicine, and Email-Based Services
8. Care Provided Outside the Four Walls
9. Same Day Billing Restriction
10. Poor Reimbursement for HBA Codes

Interviewees included:
- Nancy M. Callahan, PhD, IDEA Consulting
- Clayton Chau, MD, PhD, Orange County Health Care Agency
- Mike Geiss, Geiss Consulting
- Brenda Goldstein, Psychosocial Services Director, LifeLong Medical Care
- Michael Heggarty, Director, Nevada County Behavioral Health
- Kathy Montero, Deputy Director of Behavioral Health, Glenn County
- Elizabeth Morrison, LCSW, MAC, Golden Valley Health Centers
- Martha Paine, Director, General Fund Financial Services, Santa Clara County
- Louise Rogers, Deputy Chief, San Mateo County Health System
The moral of this story?

• Working together using the partnership model of bidirectional care is almost always the best way to succeed at managing complex cases and getting paid in the current environment.

Leveraging Who Works Where to Get Paid

• Strategic employment of behavioral health clinicians – in the Health Center or in the Behavioral Health Center – can make the difference in whether you get paid or not.

• Although the conventional wisdom is to try and bill through the Health Center to access the PPS rate, there are many instances in which behavioral health clinicians working for the behavioral health center stationed at the Health Center is the best solution.
Barrier 1: Health Center Billing of Mental Health and Substance Use Services

• Integration at an FQHC almost always requires a “Scope of Project Change”
  – Change in Services, Sites, and/or Providers

• Sound simple, but...
  – California has a lengthy and complex process
  – Opens a potential Pandora’s Box of rate review

Barrier 2: Limitations on Who Can Bill for Services

• HRSA regulations limit which behavioral health providers can bill for services to:
  – Psychiatrists
  – Psychologists
  – psychiatric nurse practitioners, and
  – licensed clinical social workers

• “If grant funding is available and you are faced with a shortage of LCSWs, Elizabeth Morrison at Golden Valley Health Centers suggests hiring CSWs who are working toward their license, funded through grant dollars, and shift their funding to billable services when they become licensed. This has the added benefit of helping address workforce shortage issues.”

• Latest Question: Can providers who can’t bill work under the license of a billable provider, providing “incident to” services?
Barrier 3: Psychiatric Consultation to Primary Care Provider or Care Manager

- Louise Rogers pointed out that in California, Medi-Cal mental health rules in fact allow for these types of phone calls and pay by the minute. This solution, however, requires that the consult is coming from someone outside the Health Center.
- The lesson then is twofold – there is a solution, and the solution is to be careful how fully you have integrated your system.
- **If the consult is coming from someone within the Health Center, it cannot be billed, whereas if it is coming from an outside specialist, even one based in primary care, it can be billed.**

Barrier 4: Lack of Codes for Non Face-to-Face Psychiatric Consultation, Care Management, and SBIRT

- 3 CPT Manual Sections
  - Evaluation and Management (99201-99340)
  - Psychiatry (90801-90899)
  - Health Behavioral Assessment (96150-96155)
- Not all “turned on” by payors (e.g. SBIRT 99211, 99408 and 99409)
- No CPT codes for non-face-to-face services
- CA Health Centers cannot bill for group
Barrier 5: Barriers to Team-Based Care
Barrier 9: Same Day Billing Restriction

• Cannot bill multiple providers for the same visit or multiple visits on the same day in health centers

• Solutions?
  – Adjust the PPS rate
  – Grant funding
  – Use clinicians working for the behavioral health center

Questions?

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Q: If billing medi-cal is the requirement that the service provider be a licensed clinical social worker - can they be an MFT? - can they be interns?
Q: If billing medi-cal does the assessment need to be as complicated as the 'specialty MH" which often
Q: Will you be talking about setting reimbursement rates for both MH and FQHC?
Q: Or are you aware of any specific implications related to Meaningful Use implementation.
How You Will Get Paid Tomorrow: New Healthcare Reform Payment Models

California is Sooooo...
Fee for Service Centric
Transitional Payment Models: Health Homes

- Three Layer Payment Model

  - Case Rate: Prevention, Early Intervention, Care Management for Chronic Medical Conditions
  - Fee for Service/PPS: Per Service Payment, Prospective Payment System (PPS) Settlement (FQHC model) to cover shortfalls
  - Bonus: Share in Savings from Reduced Total Healthcare Expenditures (bending the curve)

Subscription Health Home Payment Model

- The Individual, Purchaser, or Medicaid pays the practice a monthly “subscription fee” for each patient who signs up
Bundled Payments/Case Rates

Bundled Payments

- Hospital + Physician Services
- Pay for portion of PACs (i.e. 50%)
- Include all Costs (including 30/60/90 days post-discharge, including any readmits)

Bundled Payments with a Warranty in the Outpatient Setting: Diabetes Care Management

Diabetes ECR PAC Costs
Epilogue: The Customization of the Medical Home

A Health Home Example

The Group Health Cooperative Story

2002-2006: Move towards Medical Home

- Email your Doctor
- Online Medical Records
- Same Day/Next Day Appointment

2007: More robust Healthcare Home Pilot

- Added more staff (15% more docs; 44% more mid-levels; 17% more RNs; 18% more MAs/LPNs; 72% more pharmacists)
- Shifted to 30 minute PCP slots

(Broke even in the first year, reduced ER usage by 29%, reduced inpatient usage by 6%, reduced PMPM costs by $10.30 over the 21 month pilot)
But what about folks in the Safety Net?

• For many children, families, and adults in the safety net, good healthcare is not enough
• Consider a mom with depression and diabetes
• Add to this scenario the facts that she is the head of household of a family of three, has lost her job, is experiencing domestic violence and she and her children are on the brink of homelessness

A Key Part of the Equation: Addressing the Social Determinants of Health

• There is a distinct relationship between an individual’s health status and the social and environmental conditions in which he or she lives
• The US healthcare system is not currently structured to address these problems, separating health from human services
These and other Challenges Necessitates the “Customization” of the Medical Homes

• Analogy: Generic Hospital Beds and ICU
• Customization of Medical Homes – different models for different needs
  – Seniors in nursing homes
  – Youth in Families receiving TANF
  – Adults with a Serious Mental Illness
• Person-Centered Healthcare Homes in Mental Health/ Substance Use clinics will be one of many designs used to improve quality and bend the cost curve

A 2nd Health Home Example

<table>
<thead>
<tr>
<th>Quadrant II</th>
<th>Quadrant IV</th>
</tr>
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<tbody>
<tr>
<td>The Population: Moderate to high behavioral health and low to moderate physical health complexity/risk.</td>
<td>The Population: Moderate to high behavioral health and moderate to high physical health complexity/risk.</td>
</tr>
<tr>
<td>The Model: Person-Centered Healthcare Home: primary care capacity in a behavioral health setting, including medical nurse practitioner, primary care physician, nurse care manager, wellness programming, monitoring and tracking for health status concerns, and stepped care to a full scope healthcare home. Access to the array of specialty behavioral health services.</td>
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Person-Centered Healthcare Home Development

Fully Integrated or Focused Partnership Healthcare Home

Supporting Mental Health and Substance Use Services in Primary Care

CBHO with Embedded Medical Clinic

Providing Primary Care Services in Community Behavioral Healthcare Organizations

Food Mart CBHO

CBHO with Embedded Medical Clinic

Providing Primary Care Services in Community Behavioral Healthcare Organizations

Food Mart CBHO
A 3rd Health Home Example

- The Fulton County Georgia (Atlanta area) Health Home One Stops:
  - Well patient care
  - Sick-patient care
  - OB/GYN services
  - Travel immunization services
  - Communicable disease intervention
  - WIC/nutrition education
  - Oral health services
  - Behavioral health services
  - A day center for parents receiving services
  - Employment assistance
  - Disability and vocation rehabilitation services
  - Foreclosure prevention services
  - Housing assistance
  - A reading room/information center that offers ESL classes
  - A farmer’s market
  - A community garden
  - A walking trail

Questions?

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